

NSW Chronic Care Program

Strengthening general practitioner
involvement in chronic care

Review and recommendations



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Executive summary

Background

Chronic illness presents a growing challenge to health care services in Australia. This growing challenge results not only from the increasing burden of chronic illness generally but also from the health system's traditional focus on acute episodic care, rather than on provision of integrated care systems for chronic conditions across the care continuum. Integrated care is particularly important for patients with chronic conditions who require ongoing access to a range of services by multiple providers in settings including the home, community, general practice and hospital. In Australia it is estimated that as many as half of patients with chronic diseases do not receive best practice management.

General practitioners have a key role to play in providing well-coordinated chronic care as part of a multi-disciplinary team. They are generally the initial point of contact for people with chronic illnesses and play a key role in prevention, diagnosis and management of chronic disease in the community. Their role and workload are being increasingly impacted upon by the growing focus on supporting people with chronic illnesses in their home and community environment.

Phase one of the NSW Chronic Care Program saw the successful engagement of local general practitioners and Divisions of General Practice in a number of priority health care programs across NSW, to improve the continuity of care of patients with chronic conditions in their region. An important initiative in phase two of the NSW Chronic Care Program is to identify and implement critical factors for success in engaging general practitioners and NSW Divisions of General Practice.

This report seeks to inform Area Health Services of innovative initiatives across NSW and elsewhere and to inform future NSW Health policy, including models for chronic care management. It does so by reviewing information obtained from:

- literature (peer reviewed and 'grey' literature) on:
 - chronic disease management
 - integration and general practitioner (GP) engagement
 - current policy (national and international)
- semi-structured interviews with:
 - general practitioners
 - representatives of Divisions, including executive officers, program managers and Division Board members
 - Area Health Service staff, in particular staff linked with the local priority health care programs.

Current initiatives for integration of chronic care services

In NSW, integration of chronic care service provision is currently being promoted by:

- Commonwealth initiatives provided through the Medicare Benefits Schedule to encourage and reward GPs for undertaking multi-disciplinary and continuing care, such as Enhanced Primary Care (EPC), the Practice Incentive Program, Service Incentive Payments, More Allied Health Services and MedicarePlus
- NSW Health initiatives including:
 - NSW General Practice Council which reports to the Minister for Health and is considering integrated and coordinated models of care involving general practice
 - NSW Chronic Care Program which has been responsible for several key initiatives that support integration and best practice care, such as Clinical Service Frameworks for heart failure, respiratory disease and cancer, *My Health Record*, the NSW Chronic Care Collaborative and *NSW Aboriginal Chronic Conditions Area Health Service Standards*
 - Primary Health Care Networks
 - *NSW General Practice Information Management and Technology Strategy* and Health elink
 - NSW Health Effective Discharge Planning Framework
 - *Framework for integrated support and management of older people in the NSW health care system 2004–2006*
 - Transition care for young people with chronic illnesses

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- Other models of integration, including multi-purpose services, coordinated care trials, Divisions and Hospitals Integration Program, After Hours Primary Medical Care Program, National Demonstration Hospitals Program, Hospital in the Home, and co-location or close location of primary care facilities.

Barriers and challenges to integration

The literature and stakeholder interviews identify a range of barriers to effective integration of chronic care services. These relate to:

- the complex nature of many chronic illnesses and the systems of care required for their optimal management
- the different and sometimes conflicting drivers and incentives under which the various stakeholders, including Commonwealth, States, Area Health Services, GPs and people with chronic illnesses operate
- inadequate communication between care providers
- the complex mix of Commonwealth and State funds that together provide the various aspects of care for people with chronic diseases across the continuum of care also leads to difficulty in operating integrated systems of care.

Successful strategies for facilitating integration

Effective working partnerships between the various providers of chronic care services are essential to successful integration of care. Divisions of General Practice have been a driving force in facilitating GP/hospital integration over recent years. At a local level, clinical champions or executive sponsors in Area Health Services and Divisions are another key driver for integration, providing leadership for effective change management.

There is now significant evidence supporting a coordinated team approach to the delivery of effective clinical care for chronic illness. In the Australian healthcare system, GPs are key members of this team, given their role as providers of the key elements of chronic care across the care continuum. The active engagement of GPs in the development and joint implementation of chronic care initiatives is crucial to their success.

Establishing integrated care generally requires a change in individual and institutional attitudes, management structures and inter-relationships and approaches to care.

Recommendations

The following key principles are the basis of successful integration of chronic care:

- Well-being of the person with chronic illness should be the common objective of all providers of chronic care services and the primary focus of integrated care.
- Commitment of all key stakeholders is required to effect meaningful change. Clinical and executive champions as well as Divisions of General Practice can play an important role in fostering this commitment.
- Successful integrated care is reliant on service providers being able to communicate in a timely and effective way, either directly or in terms of access to appropriate services.
- No single strategy or approach alone will ensure integration and effective partnerships, rather an approach incorporating several strategies has been found to be the most effective.
- Achievement of integrated care between Area Health Service providers and GPs may only be possible among clusters of GPs or in limited settings, but closer collaboration or better-coordinated care which falls short of integration is a preferable alternative to autonomous operation of care providers.

Within the context of these underlying principles, and on the basis of evidence from the literature review and information from stakeholder consultation, the following strategies are recommended to Area Health Services to strengthen GP involvement in chronic care initiatives:

Formal integration strategies

- Develop formal collaboration mechanisms, such as Memoranda of Understanding with Divisions of General Practice. These should declare mutual expectations and goals with identified performance indicators.
- Agree terms of engagement and processes for Division and/ or GP representation. These should include appropriate remuneration for GPs involved in Area Health Service meetings and service planning activities.

- Where multiple Divisions correspond to Area Health Service boundaries, agreements should, if appropriate and feasible, be with a consortium of Divisions.
- Where possible, Memoranda of Understanding should be linked to a joint budget, comprising funds for integration projects, to be accountable to the joint executive. The existence of joint funding, with a delegated authority or executive committee, ensures that programs are action and outcome focused.
- Area Health Services develop local systems and agreements, under the auspices of the local MOU, which reflect the contribution of general practice in Area Health Service integrated care and service planning. For specific programs or in large (metropolitan) Area Health Services, where service relationships are between the local health service and Division, service level agreements (SLAs) are recommended. The SLA should detail the individual roles, responsibilities and performance indicators.
- Service planning and development of programs should actively involve appropriate general practice representation and be cognisant of general practice initiatives.

Common or agreed systems for organising care

- Establish GP Liaison Officer positions to provide an advisory role to Area Health Services with respect to general practice, and act as a conduit between Area Health Services, Divisions and general practice to ensure access to a consistent general practice perspective for Area Health Service staff. These positions can also act as facilitators for further consultation with local GPs.
- Develop job descriptions of positions with intersectoral responsibilities to include a requirement to liaise with Divisions and GPs.
- Co-locate appropriate liaison positions in Divisions of General Practice to build capacity and knowledge about general practice clinical and business agendas. This strategy can facilitate the education of staff from both organisations about the corporate agenda, and the cultural and business issues for their counterpart.
- Explore local options for improving (and streamlining) methods for accessing both service information and services themselves by way of Area-wide call centres, computer-based directories or nominated contacts.

Shared methods for enhancing quality

- Encourage and facilitate opportunities for joint education sessions between Area Health Services and Divisions.
- Support innovative approaches to the development of strong working relationships, support structures, patterns of referral and education and peer-support opportunities between general practice and hospital based professionals. This may include capacity building programs for special interest GPs to benefit from specialist input and be better equipped to support their peer group in general practice.
- Facilitate evidence-based changes to GP/clinical practice through use of GP liaison officers, practice nurses and joint education sessions.
- Raise the profile of local integrated care projects and programs through clinical leaders.

Abbreviations

ADGP	Australian Divisions of General Practice
AHMAC	Australian Health Ministers Advisory Council
AHS	Area Health Service*
CCT	Coordinated Care Trial
CGPIS	Centre for General Practice Integration Studies
COPD	Chronic obstructive pulmonary disease
DHIP	Divisions and Hospitals Integration Program
Division/s	Division/s of General Practice
EPC	Enhanced Primary Care
GAP	Government Action Plan
GP/s	General Practitioners
GPLO/s	General Practice Liaison Officers
MBS	Medicare Benefits Schedule
MOU	Memoranda of Understanding
PIP	Practice Incentives Program
SIP	Service Incentive Payment

* From 1 January 2005, Area Health Service boundaries changed in NSW. A map of the new Area Health Services is included in Appendix B.

Introduction

1

Background

Chronic diseases represent a growing burden to health care services in Australia, particularly in general practice where activity associated with chronic diseases is increasing. There is much evidence to support the delivery of well coordinated care by a multi-disciplinary team, with the general practitioner as the key health care provider for people with chronic diseases.^{1,2} However, in Australia it is estimated that as many as half of patients with chronic diseases do not receive best practice management. Multi-disciplinary care in Australian general practice is limited when compared with health systems in the UK and United States.²

Under the NSW Chronic Care Program, phase one, a number of priority health care programs across NSW successfully engaged local general practitioners (GPs) and Divisions of General Practice (Divisions) in order to improve the continuity of care of patients with chronic conditions in their region.³ The NSW Chronic Care Unit commissioned a review to collate and report on effective strategies for GP integration in chronic care, to inform Area Health Services of innovative initiatives across NSW and elsewhere, and to inform future NSW Health policy, including models for chronic care management.

The review focused on programs relating to cardiovascular disease, including diabetes, stroke and heart failure, and respiratory diseases such as asthma and chronic obstructive pulmonary disease. The review was supported by an advisory committee, with membership drawn from general practice, the NSW Alliance of Divisions of General Practice, Divisions of General Practice, a consumer representative and NSW Health. (For Advisory Committee membership, see *Appendix A*.)

NSW Chronic Care Program

The NSW Chronic Care Program, previously the NSW Chronic and Complex Care Program, was launched in 2000 for a three year period.⁴ The program was established on the basis of international and national literature which concluded that after mental illness, chronic illnesses such as respiratory diseases, diabetes, cardiovascular diseases and cancer represented the

greatest disease burden for the NSW Health system, accounting for 36 per cent of public hospital bed days in 1999/2000. As a comprehensive mental health program was already in place, the initial three-year phase of the Chronic Care Program focused on the priority health areas of cardiovascular disease, including diabetes, stroke and heart failure, respiratory diseases such as asthma and chronic obstructive pulmonary disease, and cancer.⁴

A total of \$45 million was allocated to Area Health Services across NSW for the period from 2000 to 2003 to improve services for people with chronic illness.

The key achievements of this first phase included:

- Key policy frameworks developed and disseminated, including:
 - Blueprint document outlining policy directions for chronic care in NSW⁴
 - Clinical Service Frameworks for heart failure, respiratory disease and cancer^{5,6,7}
 - *My Health Record*, the patient held health record.⁸
- Sixty priority health care programs established across NSW focusing on the priority health areas. Through these programs:
 - over 200 staff were employed to work with people with chronic illness across NSW
 - over 42,000 patients were enrolled
 - over 56,000 bed days were avoided, equating to a saving of 89 hospital beds throughout NSW during the approximate two years of operation of these programs.³

The benefits of health service providers working in collaboration to improve health outcomes for people with chronic illnesses and their carers is well documented.^{1,9,10} The local priority health care programs have been an ideal means whereby Area Health Services can develop partnerships with GPs via Divisions of General Practice to achieve integrated models of care and better outcomes for this patient population.

Introduction

Area Health Services were required to report regularly to the NSW Chronic Care Unit on the performance of the priority health care programs against a range of key indicators. Included in these reports were details of the approaches or strategies that Area Health Services adopted to achieve integration of care with local GPs and Divisions.

The NSW Chronic Care Program has now entered its second phase (2003–2006), seeking to build on the original program aims and to disseminate effective practices across NSW. As part of this second phase the NSW Chronic Care Program aims to support Areas to develop relationships with GPs and Divisions and to improve the patient-centred focus of chronic disease management in NSW. The collation and review of effective strategies from the first phase of the NSW Chronic Care Program will provide Area Health Services with a collection of recommendations and principles to support them in engaging GPs and Divisions during the second phase of the program.

Purpose of this report

An important initiative in phase two of the NSW Chronic Care Program is to identify and implement critical factors for success in engaging general practitioners and NSW Divisions of General Practice to improve the continuity of care of patients with chronic conditions.

This report identifies strategies that have been adopted by Area Health Services, Divisions of General Practice and GPs to strengthen the involvement of GPs and Divisions to improve the continuity of care for patients with chronic diseases. The challenges and barriers faced by Area Health Services, Divisions and GPs to working together are also identified.

Methodology of the review

The following is a summary of the methodology used in this review to identify strategies adopted by different programs to work in partnership with local Divisions and GPs. More detailed information, including the rationale for using semi-structured interviews to determine the local strategies, can be found in Appendix B. The following tasks were undertaken as part of the review:

- literature (peer reviewed and 'grey' literature) on:
 - chronic disease management
 - integration and GP engagement
 - current policy (national and international)
- semi-structured interviews with:
 - general practitioners
 - representatives of Divisions of General Practice, including executive officers, program managers and Division Board members
 - Area Health Service staff, in particular staff linked with the local health priority programs.

Literature review

A rigorous review of national and international literature was undertaken including relevant policy and program documentation relating to:

- chronic disease management models
- justification for delivering integrated health care services
- barriers and incentives for GPs in managing patients with chronic diseases
- barriers to GPs and other service providers working in collaboration
- roles of Divisions of General Practice.

The literature reviewed was obtained through computerised and web-based literature searches and through access to literature relating to both Commonwealth and State funded programs. Discussion with stakeholders during the semi-structured interviews provided further suggestions of 'grey' literature for review and consideration.

The results of the literature review were collated into five key domains:

- organisation and governance models
- integration strategies
- communication links
- barriers, incentives and challenges
- attitudinal issues.

These domains were presented to and endorsed by the project advisory committee and formed the basis of the stakeholder semi-structured interviews.

Table 1. Target groups interviewed

Area Health Service*	Divisions of General Practice & GPs
Far West (4)	Outback Division (2) Barrier Division (1)
Mid North Coast (0)	Hastings Macleay Division (3)
Greater Murray (1)	Riverina Division (3) Murrumbidgee Division (1)
New England (4)	North West Slopes Division (1)
Central Coast (2)	Central Coast Division (2)
South West Sydney (1)	Macarthur Division (1)** Liverpool Division (2)
North Sydney (6)	Hornsby Ku-Ring-Gai Ryde Division (2) Northern Sydney Division (3)
South East Sydney (2)	St George Division (1)
Wentworth (1)	Nepean Division (3)
NSW Health (2)	Other general practice representatives and GPs (3)

Note: Figures in brackets represent number of individuals interviewed.

* Based on Area Health Service boundaries prior to January 2005.

** Macarthur Division representative was also the representative for South West Sydney Area Health Service as the former Area Chronic Care Program Manager.

Stakeholder consultation

The aim of the consultation process was to collect information from three main groups of stakeholders on the issue of working in partnership with local Divisions of General Practice, with regard to:

- barriers and challenges to working in partnership
- strategies that Area Health Services had adopted
- specific strategies adopted by a range of chronic care programs.

Stakeholder representatives for interview were drawn from GPs, Divisions of General Practice, the NSW Alliance of Divisions and Area Health Services across four metropolitan areas and five rural and regional areas (see Table 1).

The questions used to guide the interview process were based on a review of literature focusing on:

- evidence supporting a team approach to management of patients with chronic illness
- working in partnership or collaboration with GPs
- barriers and incentives for GPs involved in care management of patients with a chronic illness.

A total of 50 individuals were interviewed, comprising 23 from the Area Health Services and 27 from Divisions of General Practice and general practice. Of the 27 Division interviewees, nine were practicing GPs who in some cases also represented their Division in an executive or Board member capacity. One hour was allocated per interview, although interviews with general practitioners were often shorter, mindful of their work commitments. The stakeholder interview template and list of stakeholders interviewed can be found in Appendix C and D.

2 Background to chronic care

This chapter provides an introduction to chronic illness, the rationale for integrated care and the current status of delivery of chronic care in NSW.

Definition of chronic illness

NSW Health has adopted the definition for chronic illness provided by the National Public Health Partnership (2001) that states:

“Chronic diseases are usually characterised by complex causality, multiple risk factors, a long latency period, a prolonged course of illness, functional impairment or disability, and in most cases, the unlikelihood of cure.”¹¹

Chronic disease is often episodic, with periods of exacerbation of the illness interspersed with return to previous functioning or to reduced or improved functioning. Further, episodes may occur and recur over several years or decades and be of varying lengths of duration.

Chronic illnesses may therefore have a significant impact on the individual's life and that of their carers. They can affect any age group. People with a chronic illness often have complex conditions including co-morbidities. This may be further complicated by complex social circumstances, often associated with limitations to mobility and consequently affecting work, social and personal activities.

Many chronic illnesses such as asthma, diabetes, heart failure and mental health problems can however be managed in a timely and effective way in a community and outpatient setting.^{12,13,14,15} Effective patient-centred chronic care is predicated on managing the needs of the individual patient across their care continuum rather than on managing a specific medical condition. The focus must therefore be on early and ongoing identification of the patient's changing needs, optimal care provided predominantly in the primary health care sector and appropriate access to acute secondary and tertiary services when required. This requires effective communication and partnerships between the patient, their GP and community and hospital based health care providers. Using a patient-centred approach improves

the quality of life and engagement of patients and their carers and enhances patient adherence to medication regimes and secondary prevention measures.¹⁶ It is also reported to improve work satisfaction of the health professionals who provide care.¹⁷

Patient-centred care also requires the GP and community-based teams to have effective links with hospitals and specialist services, ensuring appropriate access to acute services when required, and fostering an ongoing coordinated team approach to patient care. The GP is generally a patient's long-term health care provider and their involvement in providing integrated patient-centred care is therefore critical. People with chronic illness commonly have complex, varying and ongoing care needs over the continuum. They are therefore a group for whom better integration of care is particularly likely to improve outcomes.

Principles of integrated care

The World Health Organisation (WHO) defines health service integration as:

“Bringing together common functions within and between organisations to solve common problems, developing a commitment to a shared vision and goals and using common technologies and resources to achieve these goals.”

The Australian National Demonstration Hospitals Program (NDHP) Phase 3, undertaken from 1999 to 2001, had as its goal the integration of services between the acute, primary and community health care sectors. The Commonwealth and NDHP stakeholders developed a practical definition of integration that involves

“...hospitals and the primary and community service sectors working together to establish and document systems that provide a smooth transition across sector boundaries that results in improved patient care, support for carers, better health outcomes and optimal resource use.”¹⁹

Integration represents the closest relationship between service providers within a continuum that stretches from autonomy through to having linkages, mechanisms to coordinate care, and providing integrated care.^{9,19,20}

Harris and Powell-Davies⁹ describe the different degrees of care integration proposed by Boelen²⁰ as including:

- **autonomy**, where services have little overlap in service planning or delivery, and operate independently of one another with their own rules and ad hoc alliances
- **coordination**, where stakeholders have common goals and work in partnership to achieve them, but retain their independence
- **integration**, where organisations have a shared vision, formalised partnerships with a common planning and organisational framework, and have delegated decision-making authority to a single program.

The findings of the review of the NSW Chronic Care Program phase one would support the concept that there are varying degrees of integration, with the majority of health and GP services falling into the autonomy and coordination categories.

Integrated care is particularly important for patients with chronic conditions who require ongoing access to a range of services by multiple providers in settings including the home, community, general practice and hospital.^{21,22}

Integration needs to take place at both an organisational level involving policy and decision-making as well as at a service delivery level, between different care providers.²¹ Effective communication at both these levels can enhance planning and subsequently contribute to service reorientation needed for integration. Acknowledgement by all service providers that the primary focus of integrated care is the wellbeing of the patient provides a common objective for achieving care integration.²¹

It is widely recognised that one of the main factors hindering the development of integrated care models has been the focus of health systems on acute episodic care rather than on integrated care systems for chronic conditions across the care continuum.²² The Independent Pricing and Regulatory Tribunal (IPART) review in 2003 noted the need for a generic chronic disease model in NSW, and a national review of health care also agreed on directions for reform.²³ The Australian Health Ministers Advisory Committee (AHMAC) is seeking to rectify this with the development of a National Chronic Disease Strategy, as part of the National Health Reform agenda.

A range of barriers to integration exists, from strategic, resource and commitment differences, to cultural and

professional barriers, to the challenges posed by seeking to integrate care in rural and remote areas. However, the benefits of integration to people with chronic illness as well as to general practitioners and other providers of chronic care are being increasingly reported. Improved patient and professional satisfaction, improved patient outcomes and systems benefits have all been reported in the literature as resulting from enhanced integration of services.^{17,19,24} These outcomes should provide impetus to all stakeholders to ensure the sustainability of integration initiatives.

Delivery of chronic care in NSW

General practice

The GP is usually the first point of contact into the health system for patients with chronic illnesses. The average Australian makes five visits annually to see their GP and accesses approximately 11 Medicare items. A review of GPs identified that chronic disease care represented 75 per cent of the workload for one third of the GPs interviewed and 50 per cent of the workload of a further half of the GPs interviewed.²

GPs, as the initial point of contact, play a key role in prevention, diagnosis and management of chronic disease in the community.²⁵ The increasing focus to support patients in their home and community environment can result in increased workload in general practice. Given the multiplicity of health care providers involved in the care of a person with chronic illness, collaboration and continuity of care between hospital based and primary and community health services is even more important.

As at December 2001 there were over 17,000 GPs in Australia, of which 5,849 (34.1 per cent) were based in NSW.²⁶ General practitioners are independent private health care providers, remunerated via the Federal Government Medicare Benefit Scheme and patient fees. This is a blended payment system that includes fee-for-service and incentive payments. On the whole this funding system encourages GPs to focus on high volume, shorter time period consultation activity, while penalising general practice for providing coordinated and preventive care. The divide between state and Commonwealth government funding structures, as well as subspecialisation in hospitals, has impacted on the morale of GPs and their degree of isolation from hospital and community health providers.⁹

Background to chronic care

Divisions of General Practice were introduced by the Commonwealth Government to support GPs in their role as primary care providers, providing an organisational link between local health services and the general practitioner workforce.^{9,25} The first Divisions of General Practice were established in 1992, following the 1990 National Health Strategy Review.⁹ Ninety four per cent of GPs across Australia are members of a Division. The role of Divisions has developed over time, their focus ranging from being purely supportive to general practitioners in their business activities to supporting general practitioners and general practices, more broadly, in population health activities and in their interactions with other health service providers.

The future role of Divisions and in particular their role in primary health care and population health is currently under consideration.²⁷ State policy-makers and Area Health Services need to be cognisant of changes in the Divisions' role and consider this in their plans for integrated care, primary and community-based health care models. Area Health Services also need to consider how to liaise and work in partnership with the six per cent of GPs who have not joined their Division network.

The 37 Divisions of General Practice in NSW are supported by the Alliance of NSW Divisions. Established in 1998, the Alliance provides advice to the Divisions and raises the profile of general practice on a statewide basis on behalf of its 20 urban and 17 rural Divisions.

Hospitals and community health services

The NSW Department of Health provides the majority of its public sector health services through Area Health Services. The responsibility of each Area Health Service is to plan, deliver and coordinate local health services, manage resources and maintain a balance between treatment and prevention services within its geographic areas. Service delivery is in the main via acute hospitals, community-based health services and aged care facilities.

Area Health Service budgets and performance agreements are set annually with the Department. Staff are remunerated according to the NSW Health negotiated pay awards.

Patients with chronic illnesses usually enter the public health system following referral from a general practitioner seeking specialist intervention and advice, or as an acute presentation through the hospital emergency department

often followed by admission to a hospital ward. Patient access to community-based health services occurs via various routes, such as patient self referral or following an enquiry made by a relative or carer, through GP referral, or referral from hospital specialists following an inpatient hospital stay.

Community health refers to a range of community based prevention, early intervention, assessment, treatment, health maintenance, continuing and palliative care services designed to improve or maintain the health and well-being of individuals and communities. Public sector community based services are provided by Area Health Services, non-government organisations, local government and other agencies.²⁸ The health professionals (such as nursing and allied health) based in community health services are key providers of care to patients with chronic conditions, preferably as part of a multi-disciplinary team in partnership with the patient's GP and practice team.

Private specialists and hospitals

The Australian public health system is complemented by the private health service, which in addition to private GPs includes other specialists such as medical and allied health private practitioners, and private hospitals.

Private hospitals may operate for profit or as not-for-profit organisations, or they may be operated by charitable or religious bodies. Private hospitals are funded via a number of sources including private health insurance, patient payments, Medicare, Department of Veterans Affairs (DVA) and workers compensation.

Many patients with chronic illnesses may access care from private specialists, receiving treatment either at the specialist's private rooms or at a local private hospital. In addition to the complexities of ensuring patient-centred and integrated care delivery between Area Health Service providers and GPs, communication and coordinated care delivery with other private providers is essential. There is even greater opportunity for patient information to be dispersed across an increasing number of service providers. Nursing homes may also be another repository of medical information and another place for patient treatment, often provided by the patient's own GP. Care planning and case conferencing offer ideal opportunities for ensuring a multi-disciplinary team approach to patient care (including specialists) and are in theory accommodated via the Commonwealth Medicare Enhanced Primary Care initiative (described below).

Funding and incentives

There is a drive from governments, policy-makers and health managers both in Australia and internationally to achieve more integrated health care provision, particularly between general practice and other health service providers.⁹ The process of integration in Australia, however, is hampered by the division between Commonwealth and State funded health services.

This two-tiered governance and funding structure can introduce parallel programs with associated objectives, which in turn may introduce conflicting priorities for health care providers. For Area Health Services to progress integration with general practices, it is imperative that they work with the guidance and support of Divisions to find ways in which to blend their aims and agendas and maximise patient outcomes.

In NSW, integration of chronic care service provision is currently being promoted by a range of Commonwealth and state-led incentives and initiatives, as described below. Further information regarding each of these initiatives is included in the Glossary.

Commonwealth Government incentives via the Medicare Benefits Schedule (MBS)

The Commonwealth Government has recognised the need to support general practice in delivering a more coordinated approach to chronic disease management. It has done so by introducing several initiatives from 1999 onwards which encourage and reward GPs for undertaking multi-disciplinary and continuing care. Commonwealth Government initiatives provided through the MBS include Enhanced Primary Care (EPC)²⁹, the Practice Incentive Program (PIP)³⁰, Service Incentive Payments (SIP)³¹, More Allied Health Services and Medicare*Plus*.³² The aims of these initiatives are to:

- provide more preventive care for older Australians
- improve care coordination between GPs and other health professionals for people with chronic and complex conditions
- increase access in rural communities to allied health services, via GP referral
- facilitate the employment of practice nurses by GPs in areas of workforce shortage.

These initiatives have met with varying success in achieving their aims. For example, a formal evaluation of the EPC MBS Items indicated that health assessments

were initially the most readily taken up of all of the EPC package, because of the ease with which health assessments can be undertaken in the general practice setting.³³ In 2002/2003 in Australia 180,717 health assessments were reported to the Health Insurance Commission (HIC), 36 per cent of which were attributable to NSW.³¹

Care planning, which involves multi-disciplinary teams coordinating the care of the patient and encouraging the patient to participate in self-management as part of the care plan, is viewed by some as the most useful. However, revisions to the eligibility criteria for this item has left many GPs losing interest in using this item.^{2,34,35} Confusion over the requirements for involvement of other providers leading to inconsistent use, and concern over the level of remuneration have also been reported as obstacles to the use of care planning.²⁹ However, HIC data indicate that while nationally the number of care plans had fallen by 16 per cent to 230,211 in 2002/2003 compared with the previous year, in NSW there had been a slight (1 per cent) increase.³⁰

Case conferencing EPC MBS Items are the least used by GPs, reportedly as they are considered too complex, time consuming and poorly remunerated for the effort involved. In 2002/2003, only 6,689 case conferences were claimed in NSW (just over 18,000 were claimed nationally).³⁰

Amendments to the PIP scheme have more recently included provision for diabetes, asthma and cervical screening. HIC data for the financial year 2002/2003 reported 88,665 annual cycles of care for diabetes patients were completed nationwide. One third of these related to NSW activity. In 2002/2003, a total of 29,980 3+ Asthma Visit Plans were completed in Australia, of which 11,280 were attributable to NSW.³⁰

HIC data for PIP activity demonstrates that general practices across Australia are increasingly accessing the PIP Practice Nurses Initiative, with a gradual increase each quarter. At the quarter ending February 2004, of the 1,416 practices across Australia who were eligible for the PIP, 1,011 were participating in the Practice Nurses Initiative. This equates to 71 per cent participation.³⁰

NSW Department of Health initiatives

NSW Department of Health aims to provide consistent and effective health care for the NSW population, promoting best practice patient care and involving consumers and communities in the planning of services. A number of policies and initiatives have been developed which build on the principles of integration and best practice care. Many of these initiatives are specific to chronic disease management and relevant to integration with GPs. Those being undertaken by the NSW Chronic Care Program are outlined in more detail in the document *NSW Chronic Care Program Phase Two: Improving Health Care for People with Chronic Illness 2003–2006*.

At an advisory level, the NSW General Practice Council was established in September 2003 by the NSW Minister for Health. Its membership includes key general practice representative agencies and groups from across NSW. The Council provides an important link between the Department and general practice, its functions being to:

- provide expert advice to the Minister for Health and the NSW Department of Health
- facilitate the involvement of general practitioners in the development of NSW initiatives and policy
- advise on emerging issues for general practice in NSW that are of interest to the Department.³⁷

The Council is considering models of coordinated and integrated care involving general practice and the broader health system at both strategic and practical levels.

The NSW Chronic Care Program has been responsible for several key initiatives that support integration and best practice care. These include:

- Clinical Service Frameworks for heart failure, respiratory disease and cancer
- *My Health Record*
- NSW Chronic Care Collaborative
- *NSW Aboriginal Chronic Conditions Area Health Service Standards*.

Other relevant initiatives being undertaken by the Department include:

- Primary Health Care Networks³⁸
- *NSW General Practice Information Management and Technology Strategy* and Health elink³⁹
- NSW Health Effective Discharge Planning Framework⁴⁰

- *Framework for integrated support and management of older people in the NSW health care system 2004–2006*⁴¹

- Transition care for young people with chronic illnesses.⁴²

Alternative models of integration

Providing integrated care for people with chronic illnesses is hindered by the split in health funding between Commonwealth and state governments and the focus on acute episodic care in Area Health Services. Specific programs have been trialled with pooled funding arrangements. Examples of these alternative models of integration include:

- **Multi-purpose services** – there are 36 multi-purpose services (MPSs) in NSW where aged care, hospital and other associated services are brought together under a single management structure, generally in a single location in small rural communities.⁴³ MPSs are regarded as one of the most successful areas of integration of acute, community and aged care services in the health system.
- **Coordinated Care Trials** – involving use of pooled funds from both Commonwealth and State governments to facilitate a more flexible approach to service delivery typically including general practitioners, community health and aged care service providers.⁴⁴ The Coordinated Care Trials were developed to test the efficacy of multi-disciplinary care planning and service coordination in improving the health and wellbeing of people with chronic conditions or complex care needs. The first round of nine trials ran for two years. The outcomes of the trials have not been able to be generalised outside of the pilot sites.⁴⁵ A refined second round of six trials (three general and three in the Aboriginal community) started in 2002 and is ongoing, comprising more targeted interventions and carefully selected outcome measures.⁴² The Mid North Coast Coordinated Care Trial has already demonstrated good patient outcomes for Aboriginal people. This may reflect the Area Health Service wide approach taken.
- **Other models for integration of hospital and GP care** – for example, the Divisions and Hospitals Integration Program⁴⁶, After Hours Primary Medical Care Program⁴⁷, National Demonstration Hospitals Program⁴⁸, Hospital in the Home⁴⁹, and co-location or close location of primary care facilities.

- **After Hours General Practice Clinic** –
This model is operating successfully in the Hunter to increase patients access to primary medical care and pools state and Australian Government funding.
- **North Wyong Primary Care Network** –
This network has been established under the General Practice-Emergency Department Integration Demonstration Sites Program. It will integrate primary health care services, allied health and acute health services. It also aims to improve access to primary health care.
- **Integrated primary care services** –
Fifteen integrated primary care services will be developed in the next three years. The services will bring GPs and community health workers together to provide multi-disciplinary care, with a particular focus on the management of chronic and complex diseases.

3

Barriers and challenges to general practice involvement in chronic care

Barriers identified by GPs, Division representatives and Area Health Service staff

General practitioners face an increasing workload of caring for people with chronic illness, given the rising burden of chronic illness in the community and an ageing population.²⁶ A series of semi-structured interviews was undertaken as part of this review, to gauge the opinions of general practitioners, representatives of Divisions and Area Health Service staff across NSW regarding the barriers, challenges and successes to date in achieving integrated or collaborative partnerships. A range of attitudinal and logistical barriers to GP involvement in chronic care was identified.

The majority of the GPs interviewed appeared motivated to finding a balance between quality and continuity of care for their patients with chronic illness, while ensuring clinical practice met sound business principles. However, some indicated that they knew of some of their peers who felt that they could not afford the time to take an integrated approach to patient care via initiatives such as the EPC items as they were too busy managing the fee-for-service workload.

Area Health Service understanding of the general practice perspective varied amongst Area Health Service professionals, depending on the background of the individual. Those who had prior experience of working in general practice or closely with GPs via Divisions were much more understanding of the business pressures upon GPs, and the Divisions' perception that Area Health Services are rigid and bureaucratic. Those who had no experience of working in the general practice environment had a tendency to be dismissive of general practice and Divisions as often being unco-operative and obstructive.

The challenges identified by GPs and Divisions were in some respects different to those of Area Health Services, reflecting the differing perspectives of these groups. In other instances, both groups identified similar issues and concerns. These are presented below.

GP/Division representation at meetings

GPs and Division representatives

- Perception that input of general practice was not valued and contributions made by general practice not heeded when they attended Area Health Service meetings.
- Focus of meetings often appeared to be predominantly acute care focused.
- Area Health Services accommodated their own staff work commitments and hours without considering the implications for GPs of meetings scheduled during busy surgery opening hours such as Monday mornings or mid afternoon.
- Frustration with the bureaucracy of the Area Health Service system and a lack of positive actions or outcomes from Area Health Service meetings.
- Many felt that Divisions, if given the opportunity to lead integrated care between GPs and Area Health Services, would have greater success and be able to provide measurable outcomes.

Area Health Services

- GP and Division meeting attendance generally seen to be sub-optimal but no Areas indicated that they had investigated the reasons for poor GP/Division attendance.
- Confusion when GP representation or input had been sought and given, only to presume that this represented endorsement on behalf of all GPs. Some Area Health Service providers were mindful that over time they had learnt that the view of one GP did not represent a consensus view of all GPs, or necessarily the Division.

GP agenda and initiatives

GPs and Division representatives

- Perception that Area Health Services do not have knowledge of Commonwealth funded general practice initiatives, GPs' business agenda and Division (business) responsibilities. Therefore, they have difficulty persuading general practices to participate in their Area Health Service programs and initiatives.

Area Health Services

- Acknowledged awareness of the existence of various incentive payments, but have limited understanding of how the incentives may relate to Area Health

Service programs, funded by the State government. Stakeholder interviews with GPs and Divisions reinforced the need for Area Health Services to interpret their local programs into the agenda for general practice, in order to achieve support.

Remuneration

GPs and Division representatives

- Many Area Health Services now offer remuneration to GPs for attending and contributing to planning workshops and meetings. However, there is no consistent approach to remuneration by Area Health Services and reluctance in some instances to reimburse GPs for the time contributed.
- The situation is confused depending on whether the GP is officially representing the Division (in which case the Division will sometimes remunerate the GP), or attending Area Health Service meetings to offer a general practice perspective on health care delivery.

Area Health Services

- Some Area Health Service staff interpreted GP requests for remuneration for their time and input as being prohibitive, implying they had opposing philosophies and objectives and did not therefore have the care of patients as a primary consideration.
- Several Area Health Services reported that efforts to promote local programs and education sessions had been poorly received by Divisions who had demanded excessive costs for access to the Division newsletter or other communication processes.

Changing GP practice

GPs and Division representatives

- GPs reported barriers to making changes to referral and clinical practice as including:
 - Receiving a barrage of information regarding new processes, guidelines or initiatives from services across Area Health Services.
 - Where referral patterns or Division boundaries are across Area Health Services, there may be different or conflicting processes so that changing their pattern of care for a small proportion of their daily patient activity may not be simple or a priority.
 - Information about services relating to only a small proportion of the GPs consultation activity (or relating to an area of limited interest to them personally), is unlikely to be acted upon.

Area Health Services

- Some reported difficulty in trying to influence GP uptake of new processes, programs or clinical guidelines that they initiate, despite their best efforts.

Program sustainability

GPs and Division representatives

- GPs sometimes reluctant to participate in or refer patients to programs, as programs tend to be time limited or because the program has stalled due to staffing problems and therefore the service might no longer be available (perceived by Divisions and GPs as reflecting a lack of commitment to ensure staffing of primary care programs over acute hospital services).
- Perception that Area Health Services place a (political) focus on the delivery of acute services and that commitment to delivering primary health care is minimal.

Rural/metropolitan issues

GPs and Division representatives

- GPs from metropolitan Divisions commented that developing relationships with hospital specialists in metropolitan services was difficult and they often felt they were not valued as the primary care provider.
- Rural GPs acknowledged that their relationship with the Area Health Service providers was usually active, due to their dual role as GP and hospital visiting medical officer (VMO), but identified workload pressures as a barrier (eg waiting times for an appointment with a rural GP coupled with the onerous paperwork associated with claiming for EPC items are often viewed as a barrier by rural GPs to using EPC care plans and case conferences).
- Rural and regional GPs trying to collaborate with their local Area Health Services to implement new models of care were frustrated by the expectation that metropolitan focused initiatives and best practice models can be readily applied to rural NSW.

All stakeholders

- No consistent message from stakeholders as to whether collaboration and delivery of integrated care with GPs poses more challenges in rural or in metropolitan communities.
- Both rural and urban/outer metropolitan areas are experiencing GP workforce retention issues.

Complexity of funding systems and agendas

Division representatives

- Divisions of General Practice generally seemed to see the Area Health Services as peer providers, without always acknowledging the complexity of the state public health system and the focus of local political pressure.
- Those Division executives and staff members who had previous work experience in the state system were cognisant of the Area Health Service focus and were more able to work in partnership with former colleagues.

All stakeholders

- All stakeholders and organisations acknowledged the added complexity of having to work with both the Commonwealth and State funding systems and both government agendas.

Communication of patient information

All stakeholders

- A number of stakeholders interviewed criticised the quality of communication between providers. Some GPs reported that AHSs sometimes did not provide GPs with timely information or facilitate ready access by GPs to services on behalf of patients.
- While criticism was usually directed towards Area Health Services for poor communication of patient information to the GP post discharge, there was also acknowledgement that general practitioners have a responsibility to ensure that patient information given to Area Health Service providers is comprehensive and relevant.

Accessing services

GPs and Division representatives

- GPs reported frustration at the time taken to seek access for their patients to community-based health and aged care services.
- Reported barriers to accessing services include:
 - the belief that services (especially if delivered as part of a program) will no longer be available at the time of referral
 - uncertainty about referral criteria, service availability and waiting times
 - confusing labelling of services (ie services are given a name which does not identify the nature of the service) such that GPs are not able to locate the service under a generic service name.

Multi-disciplinary teams working from GP practices

GPs and Division representatives

- Solo GPs and small practices may lack facilities to accommodate another health professional, even on a rotating sessional basis.
- Not all GPs appreciate the potential revenue possibilities as well as positive patient outcomes that can flow from employment of this strategy.
- General practices that are not accredited are eligible for EPC items but cannot benefit from PIP or SIP payments.

Division/Area Health Service boundaries

All stakeholders

- Some Area Health Services reported having multiple Divisions of General Practice to work with, who may differ in aims and philosophy. Conversely, some Divisions border with more than one Area Health Service and face the same issues.

Discussion

A recent study by Oldroyd et al of Australian GPs' views of caring for people with chronic illness concluded that there are a number of reasons why GPs might be reluctant to involve themselves in chronic disease management.² These include:

- the perception that chronic disease management is more complicated and time-consuming than acute care
- that the goals of care and hence evidence of progress are not as clear
- that it calls for a range of roles and leads to tensions between being a business person, patient support and evidence-based clinician
- the pressures of ongoing and wide-ranging patient expectations, and the effect of patient involvement on outcomes
- being unaware of the range of services that exist for patients with chronic illnesses and how to access them
- that the structure of remuneration for GP consultations still acts as a disincentive to providing the type of care required for chronic illness, such as longer consultations and home visits.²

The findings of the interviews undertaken for this review reflect many of the concerns raised by Oldroyd et al in their survey of GPs' attitudes to chronic care.² Some of

the reported barriers relate to the nature of chronic illness itself and the systems of care required for its optimal management. Management of many chronic diseases is complex in terms of the ongoing and varying nature of the care required to maintain good health in a community setting. Evidence now clearly indicates the benefits for patients with chronic diseases of systems of care such as care coordination, ongoing self-management support, multi-disciplinary care and related activities such as discharge planning, case conferences and provision of care plans.^{5,6,7} In addition to providing evidence-based clinical management of chronic disease to individual patients, health professionals are therefore also required to engage in effective partnerships with each other and with patients to ensure optimal chronic care.

Another key barrier to integration is the fact that the different stakeholders are operating under different and sometimes conflicting drivers and incentives.⁵⁰ While the Commonwealth, States, Area Health Services and GPs share a common desire for a flexible health system that is both effective and efficient, beyond this point, their responsibility and focus diverge. For example, the focus of the Commonwealth is on supporting general practice as a core element of effective primary health care, while NSW focuses on the efficient and effective running of State funded and managed health services. Area Health Services aim to run services that balance both financial and service demand. GPs wish to ensure better continuity of care and run a viable business. Patients with chronic illnesses want continuity of care, access to healthcare providers, a GP who takes time, communicates well and deals with psychosocial as well as clinical issues, who works in partnership with the patient and provides ongoing support for self-management, and has good support staff such as receptionists and practice nurses.⁵¹

Even within Area Health Services, there are numerous perspectives and imperatives, across subspecialties as well as between acute and community-based health services. Likewise there are sometimes marked differences in focus and perspective between public health service providers and private general practice. These differences are often the source of frustration between the different organisations. It is perhaps not surprising that the pressures on each stakeholder to meet their particular imperatives sometimes lead them to lose sight of or to lack empathy for the imperatives and drivers of their prospective partners in integrated care. This is reflected in many of the comments made by both GPs/Divisions and Area Health Services.

Another barrier to integration of care is the lack of effective communication. This may be a result of a lack of understanding of or empathy with the concerns of other stakeholders. More commonly, it appears to be due to time constraints brought on by high workload pressures. In some instances, it may be attributable to limitations in process or infrastructure.

Lloyd and Powell-Davies suggest that:⁵²

"...communication is a way of creating and maintaining partnerships. It can help people develop relationships, understand the issues involved from different perspectives, understand their own and others' roles, appreciate the benefits that are being achieved and generally help them feel part of a shared enterprise."

There is a considerable cost to the community and to health care professionals in terms of lost time, frustration and confusion as a result of poor or inadequate communication between care providers.²¹ While some research questions of whether improved communication between GPs and hospital-based service providers will improve health outcomes or reduce investigations or duplication of services, there is general recognition that poor communication may be associated with adverse clinical events and inefficient use of staff time and resources.⁹

One of the key drivers for change and integration amongst GPs and clinicians generally is the potential for improved transfer of patient information between care providers. The Australian health system has an abundance of service providers, agencies and programs. GPs often cite that they find it difficult to work across boundaries, because they are unable to identify who their patients should see, the extent and type of services available, and mechanisms by which patients can access these services. This is particularly the case with community-based health services and allied health professionals.⁹

Finally, policy and funding issues have also been identified as a barrier to integration. The complex requirements of some of the Commonwealth funding incentives are one example.^{2,29} The complicated mix of Commonwealth and State funds that together provide the various aspects of care for people with chronic diseases across the continuum of care also leads to difficulty in operating integrated systems of care.

4

Strategies for strengthening general practice involvement in chronic care

Harris and Powell-Davies⁹ propose that the underlying factors for successful integration of general practice with other services are:

- key opportunities that trigger change, including special funding, re-organisation of health care delivery, leaders or change agents
- benefits or drivers for patients, GPs, health systems and the community that motivate individual health workers
- capacity of individuals and organisations involved, including resources, continuity of staffing, appropriate skills, information, culture and policy
- informal and formal relationships between those involved, including mutual understanding, the quality of communication, and any competition that exists between them
- attitudes and approaches, including adaptability, inclusive decision making and planning.

Effective working partnerships between the various providers of chronic care services are essential to successful integration of care. A number of key drivers are already operating to foster integration of chronic care. These include focused Commonwealth programs and incentives, strategies under the NSW Chronic Care Program, and other NSW Health initiatives.

Divisions of General Practice have been a driving force in facilitating GP hospital integration over recent years.^{27,47} Area Health Services cannot logistically engage each and every GP within the local Area Health Service to plan services and implement change. However, Divisions of General Practice provide a formal channel for Area Health Services to liaise with the local GP workforce at an organisational level, given that the primary focus of Divisions is to support general practices to improve the health of the community.^{25,27} The strategies identified in this review reflect the important role that the Divisions continue to play in integration of care.

It is important to recognise that at a local level, clinical champions or executive sponsors in Area Health Services and Divisions are another key driver for integration, providing leadership for effective change management.^{21,53}

The characteristics of these leaders that determine their success include their personal commitment, professional credibility, quality improvement behaviours and skills, and institutional linkages.⁵⁰ Champions are well regarded by their peers, and their sponsorship and support of new initiatives give the program credibility and encourage participation.

While clinicians and managers are often called upon to take on the role of champion, it should be noted that strong consumer representatives can also be excellent champions for integrated care programs.

Consumer representative as champion

Murrumbidgee Division of General Practice established a joint executive for managing the local integrated service. The committee has very strong consumer representation. A consumer representative has been chosen as the chair of the joint executive and champion for the local integrated service. The Division reports that the leadership of this champion is a key factor in the success of the integrated service.

Research from New Zealand suggests that the gap between clinical and managerial culture can be successfully bridged if there is a more trusting relationship between clinicians and managers that is based on:

“a shared vision and on shared goals of better 222outcomes for patients and communities, within limited available resources.”⁵⁴

All stakeholders need to acknowledge that the primary rationale for integrated care is the wellbeing of the patient. This convergence of cultures provides a common objective for achieving care integration.⁵¹ It also provides impetus for all stakeholders to seek to understand each others' agendas and drivers as a starting point to initiating change.

Successful integration of care is predicated on effective partnerships between care providers across care settings. As both the literature and findings of this review indicate, this requires the commitment of all care providers to developing more integrated organisational

structures, assuming more collaborative roles, engaging in more effective communication and embracing best practice systems of care.

A range of successful strategies has been identified through interviews with stakeholders and a review of the literature. These include strategies that primarily promote effective partnerships (such as the use of formal agreements clarifying roles, responsibilities and interrelationships between parties), and those that promote communication, collaboration and sharing (such as those involving GP liaison officers, their co-location in Divisions, joint funding arrangements, joint education and shared patient record systems). The literature also points to strategies that focus on preventing the need for hospital care, shifting care to the most appropriate environment and improving transitions of care. Examples include chronic disease management programs with a community focus, hospital in the home initiatives, discharge planning, case conferences and care plans. The success of these strategies depends to a large extent on fostering engagement of GPs in a multi-disciplinary approach to chronic care.⁴⁷

The successful strategies that were identified through the interview process can be categorised as those involving:

- formal organisational structures and relationships between services
- common or agreed systems for organising care, including communication and information, record systems, guidelines and outcomes
- shared education and quality improvement strategies.⁹

Formal organisational initiatives

Formal and informal relationships are critical to the success of advancing integrated and coordinated care. These relationships occur at organisational and clinical or operational levels. The interviews identified several instances where the Area Health Service and local Division of General Practice had introduced governance models that embraced integration. Programs demonstrated a range of formal organisational initiatives, including:

- formal agreements:
 - Memoranda of Understanding
 - Service Level Agreements

- joint budgets managed by a joint executive
- GP and Division representation at Area and hospital level service planning and program development activities
- remuneration for GP attendance.

These initiatives are outlined below, with relevant examples.

Memoranda of Understanding

Formal agreements such as Memoranda of Understanding (MOU) and service level agreements (SLAs) provide a formal executive level commitment to working in partnership to better integrate care.²¹ While the presence of an MOU between Divisions of General Practice and the Area Health Service or local health service will not alone bring about integration, their presence creates a formal link between organisations and provides a framework to guide interactions in joint activities undertaken at an operational level.^{21,47,49}

A Memorandum of Understanding signals an organisational intent to work in partnership and should include:

- clearly defined aims
- roles and responsibilities of participating organisations
- expected resource commitments
- lines of communication
- performance indicators.⁴⁹

A number of the stakeholders interviewed had Memoranda of Understanding (MOU) in place with their partner organisation, although clarity of the objectives and the level of (perceived) organisational commitment varied. Some Area Health Services had set up MOUs with more than one Division in situations where multiple Divisions aligned with Area Health Service boundaries. In larger (metropolitan) Area Health Services comprising of multiple hospitals, Divisions reported the advantage of establishing a MOU with the local health services and hospitals, rather than with the Area Health Service as a whole.

Memorandum of Understanding between an AHS and local Divisions of General Practice

New England Area Health Service and the three local Divisions of General Practice have recently agreed an MOU, as part of their ongoing commitment to work collaboratively.

Key elements of the MOU include:

- nomination of key officers in the Area Health Service and Divisions of General Practice who will facilitate elements of the MOU
- stipulation of the process for recruiting GP representation, which is via the nominated officers who represent the Area Health Service and Divisions. These individuals act as conduits between the Area Health Service and Divisions, reviewing the appropriateness of requests and ensuring appropriate representation
- financial recognition of GPs' involvement in Area Health Service business through reimbursement of GPs by the requesting department or service for their contribution to Area Health Service meetings and committees. This process is also managed by the two nominated officers.

Service level agreements

Service level agreements are more appropriate for time-limited programs or for delivery of specific services. They relate to cooperative ventures and may be set up as a subsection of a MOU. Service level agreements should be based on the same principles as MOUs, namely that:

- all stakeholders see value in the partnership
- aims, responsibilities and performance indicators are clearly stated and agreed
- decision making is consultative.^{9,21}

Service level agreement

St George Division of General Practice developed and agreed a service level agreement with their local health service, rather than the large metropolitan South Eastern Sydney Area Health Service. St George Division felt that this SLA was better able to address local needs.

Joint budgets managed by a joint executive

The commitment of joint funds, under the auspices of the MOU or SLA, managed by a joint executive was also regarded as a successful strategy. Pooled funds can provide impetus for innovative initiatives and the opportunity for short term funding to implement service or process change.⁴⁷

Commitment of joint funds managed by a joint executive

Central Coast GP Collaboration Unit is supported by a budget contributed to by both the Area Health Service and the Division of General Practice. Management and allocation of the Collaboration Unit budget is overseen by a joint executive.

GP and Division representation

GP representation can range from a Division representative to a representative of general practice to simply an individual providing a GP perspective. Area Health Services therefore need to clearly define the purpose of the GP involvement being sought, in order to get the most appropriate representation. An Area Health Service may think it has achieved GP or Division endorsement of an idea only to find that they have the view of just one individual GP.

The interviews indicated that Area Health Services were often confused by the request by Divisions for clarification about the kind of representation required. Division Executives who were interviewed acknowledged that they too had a responsibility to educate interested GPs when called upon to be a Division representative. Specifically, a Division representative has the responsibility of presenting the views and principles of the Division and feeding outcomes back to the Division for action.

Remuneration for GP representative

Interviews with stakeholders suggest that the following issues are sometimes not given enough consideration by Area Health Service staff in trying to engage GPs:

- GPs run private businesses. By taking time out from their general practice activities without remuneration, they forgo income which funds practice staff and covers indemnity insurance and other practice costs. GPs argue that Area Health Services would not usually consider seeking technical support and advice from an external provider free of charge, and in this respect they are no different.
- Requiring GP attendance at meetings at times that conflict with practice surgery times results in poor GP attendance. Meetings scheduled for Monday mornings or during mid morning or afternoon surgery hours will result in poor GP uptake. Many GPs are, however, prepared to attend meetings out of business hours.
- By agreeing on a rate of remuneration for GPs to contribute to Area Health Service meetings, the Area Health Service acknowledges the value for money aspect of GP involvement. Likewise the GP in effect enters into an agreement with the Area Health Service and Division, whereby all parties understand individual expectations. Where the GP represents the Division, they report the meeting outcomes back to the Division Executive. This ensures that GPs and Divisions are represented appropriately and formally.
- GPs can be encouraged to change their practice or referral patterns if a convincing case can be presented that they can provide better patient care, work more effectively and generate income by changing practice. The value of Divisions in assisting with developing a win-win business case for presentation to GPs is crucial.

Common or agreed systems for organising care

Common or agreed systems for organising care include those relating to communication and information, record systems, guidelines and outcomes. The interviews indicated several successful initiatives are in operation, such as those involving:

- nominated points of contact
- recruitment of GP Liaison Officers

- physical co-location of GP Liaison Officers in Divisions
- implementing a coordinated multi-disciplinary team approach
- practice nurses
- shared patient record systems.

Nominated points of contact

GPs have reported frustration and time spent in seeking access for their patients to community-based health and aged care services. One of the reported reasons for the low uptake of EPC case conferencing and care planning Medicare Items is a lack of knowledge by GPs of the range of community and hospital services available, and the time taken to organise access to these services.² A number of strategies have been developed to improve GP access to services, including:

- nominated points of contact/liaison officers
- comprehensive and current Area service directories (computer or web-based) with a search option to assist service users locate service details
- nominated points of access to services, for example via a call centre.

One of the successes of the Division-based GP liaison officer role appears to be that it provides GPs with an identified individual that they can contact, whose role it is to provide support to the GP. This support may be in the form of developing care plans or convening case conferences, or facilitating access to hospital or community-based health services. The liaison officer also became a useful resource to Area Health Service colleagues, to guide integration with general practice providers and for communicating the general practice perspective and business agenda.

Recruitment of GP Liaison Officers (GPLOs)

*"A GPLO may be defined as anyone, regardless of their professional background, who is employed specifically for the purpose of improving communication and transfer of information between general practitioners and hospitals, for the ultimate benefit of patient care."*¹⁷

The introduction of positions responsible for liaison between hospitals or community-based health services and general practice is recognised as an important

mechanism in achieving integration.^{9,49} Various GP liaison models are in operation in programs across NSW. In some instances, GPLOs are medical practitioners who provide a general practice perspective to Area Health Service providers. In others they are either nursing or non-clinical staff from the Area Health Service who support GPs through the Division.

Interviews undertaken for this review indicated that:

- medical GPLOs were in the main general practitioners who were continuing to practice on a part time basis
- funding for the position came from a range of sources including Division, hospital or Area Health Service and joint collaborative funds
- roles were in most cases relatively new and job descriptions not well defined
- roles focused primarily on building relationships between clinical stakeholders and improving communication and organisational processes, as opposed to changing individual clinician behaviour.

These findings reflect those of studies undertaken by the University of NSW Centre for General Practice Integration Studies between 1998 and 2001.^{17,55}

The literature suggests that GPLOs can play an important role in chronic care. A national survey of GPLOs in 2001 concluded that they are:

"...a useful mechanism for supporting systemic and organisational links between hospitals and general practice, particularly in complex settings and with more complicated programs."¹⁷

One of the benefits of a GP undertaking the GPLO role is that they can provide a general practice perspective to Area Health Service programs and service developments. The medical GPLO has credibility among their GP peers to seek their views and input. However, Area Health Services should be mindful not to overload these positions and should ensure that the GPLO is well directed and managed.

GP recruited as a GP Liaison Officer

Central Coast GP Collaboration Unit recruited a GP as a GPLO from the pooled integrated budget. The GP acts in an advisory capacity to the AHS, raising the perspective of general practice and the priorities for GPs. The GP is also able to positively seek the involvement of their peers, as the local GPs trust their participation will be valued.

For instance, when the hospital wanted to introduce a new discharge summary, the medical GPLO was able to guide those involved in the priorities and the type of information required by GPs. Initial consultation with the GPLO was followed by broader consultation with local GPs for subsequent draft versions.

GP involvement through the medical GPLO meant that the new summaries would meet the needs of local GPs with regard to issues such as:

- timely receipt of discharge summaries ie in advance of the patient visiting them in their rooms and, preferably, made available electronically or via fax
- provision of comprehensive details regarding:
 - prescription changes and the rationale for the changes
 - ongoing care requirements
 - follow-up treatment/appointments made for the patient with other health providers
 - pathology/other test results taken just prior to the patient's discharge that may not have been available at the time of discharge, to assist in the ongoing care of the patient.

Physical co-location of GP Liaison Officers in Divisions

While not reported widely in the literature, the physical co-location of liaison officers, from either allied health, nursing or non-clinical backgrounds, within the Division was reported to have positive outcomes in terms of improving the understanding of both organisation's cultures and environment.

Liaison officer positions co-located in Divisions achieved much in the way of understanding the cultural and business issues of general practice, as well as current Commonwealth initiatives. As a result these positions were able to influence the design of local priority health care programs to reflect the needs of the general practice business agenda.

However, GPLOs located in Divisions often had poorly defined roles and performance objectives. While many felt that this flexibility was essential in order to build effective relationships with GPs, it was worthy of note that when Area Health Service chronic care budgets were reviewed, the funding for this type of post was often withdrawn. This supports the theory that if the hospital/Area Health Service clinicians and management are unclear about or not committed to the principle of integration, then the model may also be unsuccessful.²¹

GP Liaison Officer co-located in a Division of General Practice

Wentworth Area Health Service funded a liaison nurse position to support the local Nepean Division of General Practice. The nurse is co-located in the Division headquarters and reported that her physical co-location in the Division has:

- assisted with acceptance of her position by GPs
- made her available for liaison with local GPs such as for 'trouble-shooting' and other communication and integration issues between the AHS providers and GPs
- provided her with insight into the workings of general practice that she can share with colleagues in the AHS.

One of the key roles of the liaison nurse is to facilitate case conferences for local patients in collaboration with the patient's GP and local health care providers. This process ensures that:

- patients and clients receive comprehensive, coordinated care
- GPs receive remuneration via the EPC mechanism
- Area Health Service providers are able to contribute to an effective plan of care.

How the process works:

- The GP identifies a patient as having complex care needs and would benefit from a case conference. The GP (with the patient's agreement) contacts the liaison nurse to discuss the patient's needs.
- The liaison nurse contacts the patient and confirms their needs and other (current) health providers to clarify current care arrangements.
- The liaison nurse then convenes a case conference (usually at the patient's home or in the GP surgery) giving the patient and GP priority over the date and time. Area Health Service staff know that the case conferences are a priority for the team and accommodate these within their schedules.
- All case conferences are facilitated by the liaison nurse, who also takes responsibility for recording and reporting the meeting. A plan of care is developed at the case conference including review dates for the patient, agreed by all stakeholders.

- The final report is prepared by the liaison nurse and sent to the GP who reviews and finalises it with the patient. The other care providers receive a summary. The GP can then submit his/her EPC claim for case-conferencing to the HIC.

The GP can also develop a care plan following the case conference, on the basis of the report and the agreed plan of care. This is an added financial incentive for the GP.

In some instances the liaison nurse reported that she had provided training to practice staff, including practice nurses, to manage this process locally on behalf of their practice. Most GPs however, saw advantages in the support of the Division-based liaison nurse continuing this process.

The knowledge of the liaison nurse, her understanding of the Commonwealth MBS initiatives and co-location with other Division program staff means that, where appropriate, she can ensure that the patient benefits from comprehensive care while facilitating GP access to the PIP and SIP program. An example of this would be a patient with a chronic illness including diabetes, who receives a case conference and care plan, and (assuming the practice is accredited) also an annual cycle of care through the PIP payments.

Division employing Area Health Service staff in a GP liaison role

In New England AHS a service manager well versed in the EPC initiative and its processes was seconded (part time) to the local Division as the local EPC nurse/advisor. She was able to educate GPs on the merits of the EPC initiative, while at the same time promoting the Area Health Service chronic care program.

Implementing a coordinated multi-disciplinary team approach

The literature supports the concept of a coordinated team approach to managing patient care, particularly in the case of chronic illness where multi-disciplinary team membership potentially includes nurses, allied health professionals and pharmacists as well as GPs and other hospital and community based clinicians.^{1,2} Commonwealth Medicare Benefits Scheme initiatives such as EPC, PIP and Medicare*Plus* recognise the value of a multi-disciplinary team approach to the management of people with chronic conditions.^{29,30,31,32}

Integration and multi-disciplinary care planning can be fostered when Area Health Services cooperate with Divisions to set up programs where specialist nursing and allied health staff can work from general practices on a regular basis. Examples of this model include general practice-based clinics involving dietitians, mental health and/or diabetes nurses, or Divisions employing Allied Health staff to work with general practices.

Primary Health Care Networks, under the auspices of the NSW *Strengthening Health Care in the Community* strategy, are another example of where multiple providers can work together at a local community level to enhance primary health care and improve patient and client outcomes.³⁸

Division and Area Health Service working in partnership to build capacity for Aboriginal health improvement

The Northern Rivers Division of General Practice has been working in close partnership with the Northern Rivers Area Health Service to build capacity across the Area in appropriate and effective service provision for local Aboriginal community members. Strategies have included:

- establishment of structures for joint planning between AHS, Division and Aboriginal health staff and service providers
- agreement on shared goals
- development of collaborative projects.

Services that have been supported by this partnership include:

- the Aboriginal Medical Service (AMS) based at Casino, auspiced by the AHS, where a number of collaborative projects are based, overseen and supported by representative Steering Committees
- a Primary Health Care Network project which has established Diabetes Complication Assessment Clinics in close collaboration with the local Aboriginal Vascular Health Project. These now enable the provision of regular multi-disciplinary clinics in the AMS and by outreach to local communities
- establishment of information technology through assistance of the Division, to enable timely access to relevant clinical information at the range of primary care service points which Aboriginal people utilise across the Area. This is now enabling the AMS to develop more effective primary health planning and service development.

Through GP Entity funding that is managed collaboratively with the AHS, planning is underway to support the establishment of a new GP entity run through the division to service Aboriginal community members in the Eastern sector of the Area. This will support later establishment of an Aboriginal Community Controlled Primary Health Service.

Practice nurses

A number of GPs are assisted by practice nurses. As described above, Commonwealth initiatives have been introduced to encourage general practitioners to employ more practice nurses to improve access to primary care while reducing workforce pressure. The initiatives have been designed to support a GP focus on diagnosis and clinical care, with practice nurses undertaking supporting roles with regard to chronic disease management, care coordination, population health activities and other clinical support. Stakeholders reported that practice nurses provide a mechanism by which GPs can collaborate more closely with other providers to coordinate care for their patients.

Practice staff including practice nurses, practice managers and specialist nursing staff (such as diabetes nurses and Women's Health nurses), are in an ideal position to influence GP practice in relation to service changes or developments. Practice managers may be seeking to introduce register and recall systems or maximise practice income by accessing initiatives. Practice nurses may be looking for ways of improving patient education, self-management support or access to services for patients with chronic illnesses. Where Area Health Service programs and services align with practice business and patient care agendas, there is greatest opportunity for integration.

Shared patient record systems

The ongoing electronic health record (Health elink) project seeks to improve the quality and timeliness of and access to patient information.³⁹ The development of Health elink is in response to the NSW Health objective to implement an electronic health record for the state by 2010. This development, it is anticipated, will become part of the National Information Network (HealthConnect).

The two pilot sites for Health elink include the Chronic Disease Management System (CDMS) in the Hunter region and the Child Health Information Network (CHIN) in the Westmead Children's Hospital.

Chronic Disease Management System (CDMS) in the Hunter region

The CDMS is being developed by Hunter/New England Area Health Service to support the information needs of health care providers and patients with a chronic illness. It will be an electronic longitudinal collection of an individual's health information. This information can be distributed over a number of sites and between (agreed) health care providers, for example between a patient's GP, the hospital specialist and their community-based health worker. The patients will also have access to their own record via the internet. This will greatly improve communication and support the principle of integrated care.

Shared methods for enhancing quality

Influencing GP practice

Feedback from Divisions and GPs emphasised that education regarding clinical pathways and processes is best achieved by using patient related information or case studies. When trying to advise GPs of best practice guidelines or clinical pathways, they are best circulated when the GP can relate the new process or program to a specific patient event. For example, when providing a GP with a discharge letter for a patient, the discharge letter should be accompanied by a copy of the relevant guidelines / pathway. This process may be repeated on several occasions over time if the doctor has a number of patients discharged by the service. This process reinforces the use of the clinical guidelines or pathway, relating it to a specific patient event.

GP liaison officers, the majority of whom are GPs themselves, can play an important role in influencing GP practice.^{17,55}

Co-location of GP liaison officers in Division facilities

Central Coast Health reported that GP liaison officers co-located in Division facilities are able to influence GP practice, or communicate service changes and improvements through GP-support staff at the Division, who relayed the information to GPs (or practice staff) as part of their normal working practice.

Some Areas have reported success in using a range of strategies together to influence GP practice and foster increased involvement in specific programs.

Engaging GPs in a specific program

South Western Sydney Area Health Service received Commonwealth funding for a self-management pilot using the Flinders Self-Management (Partners in Health) assessment tool. The proposal was developed as a joint venture between local Divisions of General Practice, local GPs and the Area clinical divisions.

The pilot enrolled over 320 clients on to the self-management program (involving 140 GPs). The client's GP would be notified once the referral was received, and invited to either develop the care-plan or to contribute to the draft care-plan and simply receive quarterly updates on the client's progress. Initially, most GPs opted for the latter. EPC items were in their infancy and GPs were feeling overwhelmed with services trying to engage them through the EPC initiative. GPs had voiced their concerns about the time commitment involved in developing care-plans at focus groups held prior to the pilot.

However, over time the GPs became aware that their patients were better informed about their disease and medications, were taking more proactive involvement in their own wellbeing and were adhering more closely to their treatment regimens. As a result, the GPs started to refer patients to the program themselves.

The program applied a range of strategies to engage GPs:

- Consortium/joint approach to service proposal and development
- Raising awareness amongst patients via community groups and NGOs, and encouraging clients to discuss the program with their GP
- Engaging GPs when patients had indicated an interest in the self-management program, and offering the GP options as to how involved they would like to be
- Facilitating GP reimbursement via the EPC initiative for contributing to or initiating the care plan
- Providing regular (quarterly) updates on patient progress against the care plan to the GP.

The program manager explained that while progress had initially been slow, the combination of strategies to engage and involve GPs in this program had proven successful and, most importantly, beneficial to patients.

Joint education, training and development

Joint education programs are well received if they are appropriately researched and targeted. They assist in breaking down organisational and cultural barriers as well as facilitating a team approach to resolving care delivery issues.²¹ Joint education programs are regarded as a positive way to continue to build on integration and partnerships between clinicians across the organisations.

Divisions of General Practice are a good mechanism for developing appropriately targeted and scheduled meetings. They can also advertise and communicate training session details succinctly to local GPs via their regular communication networks such as newsletters and Division websites.

A number of Area Health Services and Divisions of General Practice have developed approaches to joint education and training that include hospital staff, GPs and practice nurses. The following strategies are examples of approaches to joint education and training recommended by stakeholders. They are supported by published literature.^{17,21,50,55}

Examples of joint education and training

Many Area Health Services have invited representatives of Divisions and staff from local general practices to attend in-house training sessions. Divisions of General Practice have also been active in promoting and facilitating such initiatives.

- Central Coast GP Collaboration Unit reported that a forum of hospital, Division, Community Health and Area Health Service managers provided an opportunity for each of the stakeholders to describe their service, priorities and issues. This provided the audience with insight into the different organisational cultures and agendas.
- New England Area Health Service chronic care program provides for joint training and education of Area Health Service nurses alongside practice nurses from the local GP practices. This ensures that local practice nurses have the chance to increase their skills and capacity as well as providing opportunities for networking with their peers from the Area Health Service.

- Some Divisions of General Practice have promoted the idea of undertaking joint education workshops where Area Health Service providers can receive information about the aims and objectives of Division programs and general practice initiatives. Both organisations are then able to plan how Area Health Service programs can potentially support general practice while achieving their own program objectives.
- The St George Division of General Practice encouraged the Area Health Service to provide education to GPs in small groups, with the relevant specialist/s presenting. This provides a non-threatening environment for GPs to talk and learn from clinical leaders and specialists in the field.

Area Health Services can assist in developing a sustainable GP workforce by supporting Divisions to develop programs for special interest GPs to provide care, education and support to their peers. Such programs increase the capacity of these GPs who benefit from the specialist-mentor input and are better equipped to support their peer group in general practice.

GP placements into secondary and tertiary hospital departments are also particularly well accepted among rural GPs. This strategy fosters development of strong working relationships, support structures, patterns of referral and education and peer-support opportunities.

Linking education activities with a capacity to earn continuing medical education (CME) points is another positive strategy in gaining engagement of interested GPs.

AHS in partnership with Division providing Continuing Medical Education-linked education for GPs at a specialist outpatient clinic

North Sydney Area Health Service diabetes service has (in partnership with one of the local Divisions) introduced a specialist diabetes clinic. GPs can attend (as an observer) the chronic disease patient clinic. GPs receive one to one education from the diabetes nurse with clinic patients used as case studies.

The service has attained CME points for the clinic education sessions. The education clinic has been well received by GPs, with a waiting list for GPs wishing to attend. The service reports success in developing partnerships with GPs, with increased referrals and subsequently improved patient access.

5 Conclusions and recommendations

Conclusions

There is now significant evidence supporting a coordinated team approach to the delivery of effective clinical care for chronic illness.^{1,2} Effective chronic illness care, according to Wagner, requires the collaborative efforts of a multi-disciplinary team to provide the key elements of:

- population-based care – using evidence based guidelines to plan and deliver care to defined patient populations
- treatment planning – development of formal written care plans in consultation with patients
- evidence based clinical management – using a team approach and care coordination
- self-management support – educational and supportive interventions to help patients acquire skills, enhance motivation and confidence to become better self managers
- more effective consultations – longer consultations, clinics for patients with similar needs, group consultations
- sustained follow-up – telephone follow-up can also be beneficial.¹

In the Australian healthcare system, GPs are key members of this team, given their role as providers of the key elements of chronic care across the care continuum. The active engagement of GPs in development and joint implementation of chronic care initiatives is crucial to the success of these initiatives.

Health service research suggests that the establishment of integrated care models for chronic care can help to reduce many of the gaps between evidence-based best practice and actual clinical care.^{56,57,58} Establishing integrated care generally requires a change in individual and institutional attitudes, management structures and inter-relationships and approaches to care. In planning for changes in practice, it is important to take into consideration barriers associated with the type of innovation being proposed, the professionals and patients involved in the process, and the social, organisational, economic and political context in which they operate.⁵⁶

The review that was undertaken to inform this report provides current examples from key stakeholders of the perceived barriers to and successful strategies for strengthening GP involvement in chronic care.

Integration of care between GPs, community and hospital-based providers is the avenue by which outcomes such as better health, access and continuity and more efficient use of resources can be achieved. This review outlines a wide range of strategies that are being used effectively in settings across NSW. The challenge is to foster more sustained and widespread acceptance of the underlying principles of care integration, such that these strategies and others are used more widely in moving towards closer collaboration, coordination and integration of chronic care.

Principles

The following key principles are at the basis of successful integration of chronic care:

- Well-being of the person with chronic illness should be the common objective of all providers of chronic care services and the primary focus of integrated care.
- Commitment of all key stakeholders is required to effect meaningful change. Clinical and executive champions as well as Divisions of General Practice can play an important role in fostering this commitment.
- Successful integrated care is reliant on service providers being able to communicate in a timely and effective way, either directly or in terms of access to appropriate services.
- No one strategy or approach alone will ensure integration and effective partnerships, rather an approach incorporating several strategies has been found to be the most effective.
- Achievement of integrated care between Area Health Service providers and GPs may only be possible among clusters of GPs or in limited settings, but closer collaboration or better-coordinated care, which falls short of integration, is a preferable alternative to autonomous operation of care providers.

Recommendations

Within the context of these underlying principles, and on the basis of evidence from the literature review and information from stakeholder consultation, the following strategies are recommended to Area Health Services to strengthen GP involvement in chronic care initiatives:

Formal integration strategies

- Develop formal collaboration mechanisms, such as Memoranda of Understanding with Divisions of General Practice. Memoranda of Understanding should state mutual expectations and goals with identified performance indicators.
- Agree terms of engagement and processes for Division and/ or GP representation. These should include appropriate remuneration for GPs involved in Area Health Service meetings and service planning activities.
- Where multiple Divisions correspond to Area Health Service boundaries, agreements should, if appropriate and feasible, be with a consortium of Divisions.
- Where possible, Memoranda of Understanding should be linked to a joint budget, comprising funds for integration projects, to be accountable to the joint executive. The existence of joint funding, with a delegated authority or executive committee, ensures that programs are action and outcome focused.
- Area Health Services are recommended to develop local systems and agreements, under the auspices of the local MOU, which reflect the contribution of general practice in Area Health Service integrated care and service planning. For specific programs or in large (metropolitan) Area Health Services, where service relationships are between the local health service and Division, service level agreements (SLAs) are recommended. The SLA should detail the individual roles, responsibilities and performance indicators.
- Service planning and development of programs should actively involve appropriate general practice representation and be cognisant of general practice initiatives.

Common or agreed systems for organising care

- GP Liaison Officer positions can provide an advisory role to Area Health Services with respect to general practice, and act as a conduit between Area Health Services, Divisions and general practice; ensure access to a consistent general practice perspective for Area Health Service staff, and act as facilitators for further consultation with local GPs.
- Job descriptions of positions with intersectoral responsibilities to include a requirement to liaise with Divisions and GPs.
- Co-locate appropriate liaison positions in Divisions of General Practice to build capacity and knowledge about general practice clinical and business agendas. This strategy can facilitate the education of staff from both organisations about the corporate agenda, and the cultural and business issues for their counterpart.
- Explore local options for improving (and streamlining) methods for accessing both service information and services themselves; by way of Area-wide call centres, computer-based directories or nominated contacts.

Shared methods for enhancing quality

- Encourage and facilitate opportunities for joint education sessions between Area Health Services and Divisions.
- Support innovative approaches to the development of strong working relationships, support structures, patterns of referral and education and peer-support opportunities between general practice and hospital based professionals. This can include capacity building programs for special interest GPs to benefit from specialist input and be better equipped to support their peer group in general practice.
- Facilitate evidence-based changes to GP practice through use of GP liaison officers, practice nurses and joint education sessions.
- Raise the profile of local integrated care projects and programs through the clinical lead.

Glossary

Clinical Service Frameworks	<p>A set of Clinical Service Frameworks for heart failure, respiratory disease, and cancer was developed as part of the first phase of the NSW Chronic Care Program. These draw on evidence-based practice to set standards for optimal care for people with chronic conditions across Area Health Services. They include initial milestones, targets and demonstrations of compliance within agreed timeframes. They were launched in July 2003. Area Health Services are reporting on a six-monthly basis on progress in achieving the standards and demonstrations of compliance set out in the frameworks.</p>
Coordinated Care Trials	<p>Coordinated Care Trials were introduced by the Commonwealth government to test whether planned, coordinated, multi-disciplinary care improves well-being and general health outcomes for people with chronic and complex illnesses.</p> <p>Programs involve the management of pooled funds from both Commonwealth and State governments, to facilitate a more flexible approach to service delivery. Health providers involved typically include general practitioners, community health and aged care service providers.</p>
Discharge planning framework	<p>The NSW Health Effective Discharge Planning Framework facilitates improved patient discharge between hospitals, community services and GPs. Patient-centred care is fundamental to good discharge planning. To ensure effective discharge, the management of patient care must be shared and coordinated between appropriate providers to meet the needs of the individual, and information transferred in a timely fashion.</p>
Enhanced Primary Care	<p>The Enhanced Primary Care Medicare Benefits Schedule (EPC MBS) Items package provides a framework that fosters a multi-disciplinary approach to health care through processes that streamline the matching of patients' needs with appropriate services. Practices do not require accreditation to access this initiative. EPC Medicare Item numbers are attached to:</p> <ul style="list-style-type: none">■ annual health assessments, which support the opportunity for GPs to assess the medical, physical, psychological and social functioning of the patient■ multi-disciplinary care planning, discharge planning and case conferencing – using a team-based approach to care planning across the continuum of care for patients with chronic and complex needs.
GP After Hours Services	<p>Development of service models to support the provision of appropriate and affordable primary medical care services after hours is a priority for both the Commonwealth and the State governments. GPs cite concerns regarding quality of life, remuneration and personal safety as barriers to providing comprehensive after hours care. As a result of limited access to general practice after hours, patients seek medical intervention at public hospital Emergency Departments.</p> <p>Some GP after hours service models are co-located in hospitals, close to the hospital Emergency Department. This model provides the GP with a safe working environment and with support from Emergency Department personnel. The GP after hours service can also relieve some of the Emergency Department ambulatory workload.</p>

MedicarePlus	<p>The recently introduced Medicare<i>Plus</i> package introduces new Medicare Benefit Scheme (MBS) item numbers for specific care provided by practice nurses, to support and reward general practice for innovative approaches to delivering ongoing care. Practices can now claim for specific MBS item numbers relating to immunisation and wound management provided by a practice nurse, under the supervision of a general practitioner.</p> <p>This package builds on the PIP incentive for practice nurses, extending the program to urban practices in areas of workforce shortage and allows practices to employ allied health professionals as well as practice nurses.</p>
More Allied Health Services Program	<p>The More Allied Health Services Program (MAHS) was introduced to increase access, by GP referral, to allied health services in rural communities. Programs operate in 65 Divisions across Australia and help with the management of a range of conditions including diabetes, cardiovascular disease and mental health conditions. Divisions are funded by the Commonwealth Government to employ, fund or contract allied health professionals such as dietitians, psychologists, Aboriginal health workers and podiatrists.</p>
Multi-purpose services	<p>Multi-purpose services (MPS) are a joint initiative of the Commonwealth and NSW governments for small rural communities, where aged care, hospital and other associated services are brought together under a single management structure, generally in a single location. The MPS model is flexible, providing a range of service choices and reducing the need for older people to move away from their local community to access appropriate care. Better coordination of service delivery under this model leads to improved continuity of care.</p>
My Health Record	<p><i>My Health Record</i> is a patient-held folder in which all of the patient's health information can be organised and stored. Its development and distribution was a significant initiative of phase one of the NSW Chronic Care Program. The purpose of the record is to improve communication between multiple health service providers and the patient, thereby enhancing the continuity of care. Over 120,000 copies have been distributed across NSW. A review occurred in 2004.</p>
NSW Aboriginal Chronic Conditions Area Health Service Standards	<p>The <i>NSW Aboriginal Chronic Conditions Area Health Service Standards</i> have been developed in recognition of the poor health experienced by Aboriginal populations in relation to chronic disease. The document outlines standards in chronic care for Aboriginal people. The implementation of the standards will continue to involve extensive consultation with Aboriginal communities, health workers and other service providers.</p>
NSW General Practice Council	<p>The NSW General Practice Council was established in September 2003 by the NSW Minister for Health. Its membership includes key general practice representative agencies and groups from across NSW.</p> <p>The Council was established to:</p> <ul style="list-style-type: none"> ■ provide expert advice to the Minister for Health and the NSW Department of Health ■ facilitate the involvement of general practitioners in the development of NSW initiatives and policy ■ advise on emerging issues for general practice in NSW that are of interest to the Department.

- NSW Chronic Care Collaborative** The NSW Chronic Care Collaborative is a joint initiative between the Clinical Excellence Commission and NSW Health that aims to facilitate the widespread implementation of the Clinical Service Frameworks for heart failure and chronic obstructive pulmonary disease. It draws on collaborative methodology developed by the US Institute of Health Improvement to spread evidence-based knowledge, skills and proven good practice across multiple sites over a defined period of time. The role of the GP as a key stakeholder in the care continuum of patients with chronic conditions will be emphasised and promoted through the Collaborative.
- NSW General Practice Information Management and Technology Strategy and Electronic Health Record (Health elink)** The *NSW General Practice Information Management and Technology (IM&T) Strategy* demonstrates the commitment of NSW Health to working in partnership with general practice and increasing cooperation with respect to information management between key players. Its key goals include improving communications and the sharing of patient clinical data and improving GP awareness and skills in computing and in IM&T.
- The introduction of the electronic discharge referral system (EDRS) is a key priority under the NSW General Practice IM&T strategy. The ongoing electronic health record (Health elink) project seeks to address these issues by improving the quality, timeliness and access to patient information. The development of Health elink is in response to the NSW Health objective to implement an electronic health record for the state by 2010. This development, it is anticipated, will become part of the National Information Network (HealthConnect).
- The two pilot sites for Health elink include the Chronic Disease Management System (CDMS) in the Hunter region and the Child Health Information Network (CHIN) in the Westmead Children's Hospital.
- Older people's framework for integrated support and management** The NSW Health *Framework for integrated support and management of older people in the NSW health care system 2004–2006* acknowledges the importance of integrating and coordinating care for older people with chronic illness. A multi-disciplinary team approach including the patient's GP as primary health care provider is fundamental to supporting older people to remain active and in their own home for as long as possible. Implementation of the Framework will lead to a coordinated and cohesive approach to assessing the needs and circumstances of older people and organising and providing services to meet these needs.
- Practice Incentives Program (PIP)** The Practice Incentives Program (PIP) rewards accredited general practices (or practices otherwise working towards accreditation) that provide ongoing quality health care for their patients, including provision of after hours care, the use of information management and technology (IM/IT) solutions, student teaching, practice nurse employment and quality prescribing.
- Payments made through this program are in addition to other income earned by the individual GP and practice, such as patient payments and Medicare rebates. General practice is thereby compensated for the limitations of high turnover, fee-for-service arrangements. Practices are rewarded under the PIP scheme on the basis of practice population outcomes payments rather than individual consultation activity. With some incentives practices also receive a one off, sign-on payment in recognition of the costs incurred by the practice in establishing the

processes to deliver the service, and as part of the practice's agreement to provide data to the Commonwealth Government.

Recent amendments to the PIP scheme include provision for diabetes, asthma and cervical screening.

For diabetes, under this scheme, practices are encouraged to take preventive steps towards the diagnosis and management of people with diabetes. This includes establishing patient registers and re-call systems and providing an annual program of care according to the general practice guidelines of the Royal Australian College of General Practitioners and Diabetes Australia.

For patients with moderate to severe asthma, there are incentives for GPs to provide better clinical management of the relevant practice population. Completion of a 3+ Asthma Visit Plan requires proof of a minimum of three asthma related GP consultations within a four month period, including the development of a written asthma action plan for the patient, a medication review and patient education.

The cervical screening incentive was introduced to address the poor cervical screening rates particularly amongst high risk women in Australia. The cervical screening incentive is outcome focused, as are the other PIPs. Practices receive a payment where a specified proportion of the female practice population, between the ages of 20 and 69 years, has been screened in the previous twenty-four months.

Practice nurses

The Practice Incentives Program (PIP) Practice Nurses Initiative focuses on the challenges of limited workforce in rural communities and other areas of workforce shortage. This incentive aims to enable GPs to focus on diagnosis and providing clinical care, while practice nurses play a complementary role in delivering clinical nursing services, coordinating patient care, providing health information and education, and contributing to the management and prevention of ill health (eg participating in diabetes and asthma management programs, immunisation and promotion and support of self management).

PIP accredited practices must meet a number of additional eligibility criteria in order to access this initiative, including proof of being in a rural area or area of workforce shortage, the period of employment and sessions for which the nurse is employed and the duties undertaken by the nurse. A number of Divisions have introduced innovative arrangements whereby Divisions employ a practice nurse/s, to provide a resource for member practices to buy-in. Under this incentive GPs can receive a grant for one full time practice nurse per practice, per 5,000 SWPE (standardised whole patient equivalent).

Primary health care networks

The NSW *Strengthening Health Care in the Community* strategy aims to improve the delivery of primary health care in the community through a series of Primary Health Care Networks. This initiative seeks to take a whole-of-community approach to improving the planning and delivery of primary health care services, facilitating the participation of all stakeholders (in particular GPs) in the planning and delivery of care through constructive working relationships and joint planning of services.

Service Incentive Payments

The Service Incentive Payments (SIP) program is a Medicare incentive used in conjunction with and linked to the PIP chronic disease incentives. SIPs apply to chronic conditions including diabetes, asthma and cervical screening.

While PIP payments are made by the Commonwealth Health Insurance Commission directly to the practice as sign-on and outcome payments, SIPs are paid directly to the individual consulting doctor as an additional incentive over and above the standard MBS consultation remuneration.

The SIP for mental health conditions is slightly different in that it comprises a three-step process. Individual GPs are registered for this SIP on completion of a training and education program. On registration, a sign-on payment is made to the GP. GPs then receive further payment once the client has completed a cycle of assessment, care plan and an outcome review.

Transition care for young people with chronic childhood illnesses

The Metropolitan Clinical Taskforce has developed a framework for transition care for young people with chronic childhood illnesses that aims to support the transition of children with chronic illnesses to adolescent and then adult health care services.

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Appendix A

NSW Integrated Chronic Care Working with General Practitioners Advisory Committee membership

- Professor Ron Penny, NSW Health
- Kym Scanlon, NSW Health
- Jan Newland, Alliance of NSW Divisions
- Betty Johnson, Consumer Representative
- Rene Pennock, Macarthur Division of
General Practice
- Dr Vlad Matic, General Practitioner, Walgett
- Dr Simon Willcock, General Practitioner,
North Sydney
- Gilli Appleby, Consultant

Appendix B

Review methodology and Area Health Service and Divisions of General Practice boundaries

Stakeholder consultation: Semi-structured interviews

Interviews are the most commonly used qualitative technique in health care settings. Semi-structured interviews are less structured than questionnaires or formal structured interviews. The order in which questions are asked may vary. The language and vocabulary used is flexible, and there is opportunity for the interviewer to introduce further questions as they become more familiar with the subject.⁵⁹ This approach involves the interviewer explaining the broad context of the study; its aims and objectives and then open-ended questions are presented that define the area to be explored. This approach allows respondents to answer openly, to express their opinions through discussion, and for either the interviewer or interviewee to deviate to discuss a response in further detail.

The advisory committee to the Integrated Chronic Care – Working with GPs project, recommended that respondents be assured anonymity; to encourage candid and open responses, and to therefore maximise the opportunity to collate comprehensive qualitative data.

The aim of the interview process was to collect information from three main groups of stakeholders on the issue of working in partnership with local Divisions of General Practice: the strategies that Area Health Services had adopted; the specific strategies adopted by a range of chronic care programs; and finally the barriers and challenges to working in partnership.

Stakeholder representatives for interview were drawn from GPs, Divisions of General Practice, the NSW Alliance of Divisions and Area Health Services. Divisions selected were those generally corresponding to the Area Health Services in question (see Table 1 on page 7).

The questions used to guide the interview process were based on a review of literature focusing on:

- evidence supporting a team approach to management of patients with chronic illness
- working in partnership or collaboration with GPs
- barriers and incentives for GPs involved in care management of patients with a chronic illness.

From this literature review domains for investigation were identified, and thereafter questions within the domains. The advisory committee supporting the project made recommendations and endorsed the proposed interview questions. The questions were refined further after discussion with the Associate Director, Chronic Care Unit, NSW Health, to reduce the number of questions to six key questions to meet the allotted interview time of approximately one hour (see Appendix C).

The literature review also highlighted that there are many attitudinal factors which impact upon health services' willingness to integrate with general practice. These were considered and noted during the course of each interview by the interviewer (see Appendix C).

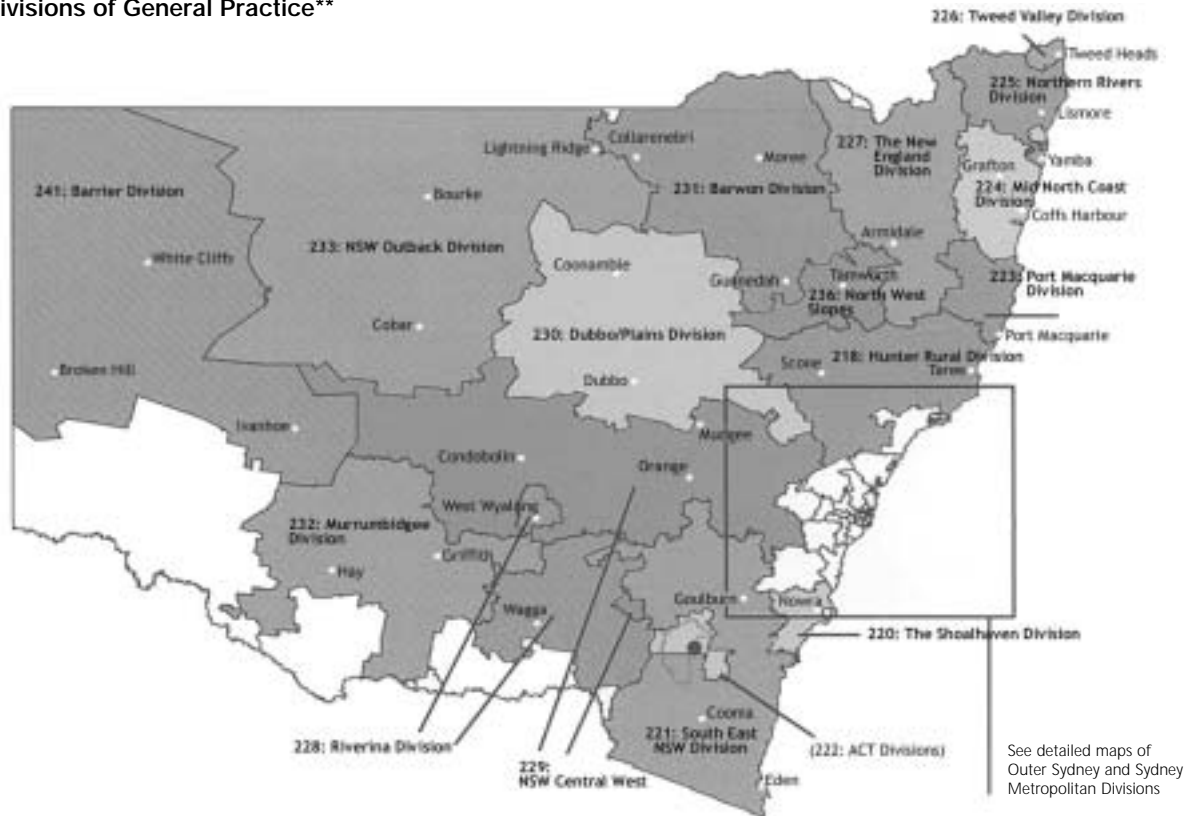
The target groups for review were selected from four metropolitan areas and five rural and regional areas (see Table 1 on page 7).

All Area Health Service and Division representatives were contacted by telephone to arrange a convenient time for interview, with interviews conducted either via the telephone or face to face. A total of 50 individuals were interviewed; 23 from the State health services and 27 from Divisions of General Practice and general practice, between 31 March and 21 April 2004. Of the 27 Division interviewees nine were practicing GPs, who in some cases also represented their Division in an executive or Board member capacity. One hour was allocated per interview, although interviews with general practitioners were often shorter; mindful of their work commitments. Details of stakeholders interviewed can be found in Appendix D.

NSW Area Health Services*



NSW Divisions of General Practice**



* These Area Health Services came into effect on 1 January 2005.

** Division maps from Alliance NSW Divisions website www.answd.com.au

Outer Sydney Divisions of General Practice*



Sydney Metropolitan Divisions of General Practice*



* Division maps from Alliance NSW Divisions website www.answd.com.au

Appendix C

Stakeholder interviews

Stakeholder interview template

Contact:

AHS/Division:

Position:

Date:

1. How is chronic disease management going in your Area?

2. Does 'your' organisation have a strategic intent to work in partnership with the local Division/ Area Health Service? (AHS and Div only)

3. What would be the factors (or people) that have influenced the relationship?

4. What strategies were used by the AHS to liaise / link with GPs either directly or via the division?

5. What 'tools' (such as EPC items) did you use?

6. What were the lessons learnt – if you could have your time again what would you do?

Attitudinal issues checklist

During the course of the interview, the interviewer will attempt to ascertain the individual respondent's attitude towards working in collaboration with partner service providers.

Interviewer checklist

Attitude checklist	Comments
Antipathy towards the other organisation/profession	
Aware of other's agenda and issues	
Resource/turf issues?	
GP attitude towards local Division representation	
GP attitude towards them needing to share information with other service providers, and responsibility towards maintaining accurate patient records.	
Level of understanding of integration and its value	

Appendix D

Stakeholder interviewees

NSW Health Chronic Care Unit would like to thank the many individuals and organisations who contributed to this study; providing information, comment and constructive suggestions for ways to improve the provision of health care to people with chronic illnesses in NSW.

- Barrier Division
- Central Coast Division
- Central Coast Area Health Service
- Far West Area Health Service
- Greater Murray Area Health Service
- Hastings Macleay Division
- Hornsby, Ku-ring-gai Ryde Division
- Liverpool Division
- Macarthur Division
- Mid North Coast Area Health Service
- Murrumbidgee Division
- Nepean Division
- New England Area Health Service
- North West Slopes Division
- Northern Sydney Area Health Service
- Northern Sydney Division
- NSW Health
- Outback Division
- Riverina Division
- South Eastern Sydney Area Health Service
- South Western Sydney Area Health Service
- St George Division
- Wentworth Area Health Service
- Additional General Practitioners.

